Behavioral Risk Factor Surveillance System (BRFSS) Asthma Call-back Survey (ACBS)

Existing Collection in Use Without an OMB Control Number

Supporting Statement

Part A: Justification

(0920-XXXX)

October 2017

Cathy M. Bailey, MS
Centers for Disease Control and Prevention
National Center for Environmental Health
Environmental Hazards and Health Effects
Air Pollution and Respiratory Health Branch
4770 Buford Highway F- 60
Atlanta, GA 30341
awl3@cdc.gov
770-488-3716

Table of Contents

List of Attachments

Goal: The goal of this information collection is to add in depth data about those with asthma (e.g., symptoms, environmental factors, medication use etc.) and their experiences (e.g., activity limitation, health system use, self-management education, etc.) to the Behavioral Risk Factor Surveillance System (OMB Control No. 0920-1061B).

Intended use of the resulting data: Information collected will be used by asthma control programs located in state health departments and at the federal level to improve tracking the disease, and for planning and evaluating interventions to reduce the disease burden.

Methods to be used to collect data: Data will be collected through a follow-up survey approximately two weeks after the Behavioral Risk Factor Surveillance System (BRFSS) survey is administered.

The subpopulation to be studied: Adult respondents (18 years and older) from BRFSS who report ever being diagnosed with asthma. Parents or guardians of children (less than 18 years), if a state includes them in BRFSS and if the randomly selected child has ever been diagnosed with asthma, then the parent or guardian will serve as the proxy respondent for the child. If both the BRFSS adult respondent and the selected child in the household have asthma, then only one or the other is eligible for the Asthma Call-back Survey (ACBS).

How data will be analyzed: Descriptive analyses (frequencies, means, etc.), tests for association, and logistic regression models are statistical methods typically used to analyze data.

A. Justification

A.1 Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) is requesting a three-year Paperwork Reduction Act (PRA) clearance to conduct information collection under the "Behavioral Risk Factor Surveillance System (BRFSS), Asthma Call-back Survey (ACBS)". ACBS is an existing collection in use without an OMB Control Number. CDC is seeking PRA clearance to continue to collect state level asthma data for next three year cycle. CDC's authority to collect information for this purpose is provided by the Public Health Service Act Section 301 [241] **(Attachment 1**).

The ACBS is sponsored by the CDC National Asthma Control Program (NACP) in the National Center for Environmental Health (NCEH). The NACP plays a critical role in addressing the health risk of persons with asthma. The program funds state health department, territorial, and the District of Columbia (collectively referred to as states) programs through the BRFSS (CDC-RFA- DP15-1513). The BRFSS request for applications (RFA) funds a state-based telephone survey coordinated by the CDC with data collection occurring concurrently in each of the 50 states, Washington DC, Guam, Puerto Rico and the US Virgin Islands.
The ACBS is an ongoing data collection administered by CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) through their BRFSS cooperative agreement with state health departments under CDC-RFA DP15-1513 (BRFSS, OMB Control No. 0920-1061, expiration date 3/31/2018). In 2003 and early 2004, the ACBS was initially implemented as the National Asthma Survey (NAS) through the State and Local Area Integrated Telephone Survey (http://www.cdc.gov/nchs/slaits/nas.htm). Since 2006, the ACBS has been implemented annually through BRFSS. The number of states participating in the ACBS vary each year. The list of states participating in ACBS is provided in **Attachment 3**. The information provided reflects the number of states that participated in 2013 and the most recent year of ACBS data released.

CDC, in collaboration with the states, provides standard guidelines for ACBS data collection which all states are encouraged to adopt (**Attachments 4)**. State BRFSS coordinators are responsible for administering the ACBS in their respective states and territories. All participating entities use the same ACBS screeners, consent forms, and questionnaires (**Attachments 5a–5f)**. State BRFSS coordinators submit ACBS datasets using data submission layout (**Attachment 5g)** to the CDC BRFSS unit for cleaning and weighting, and they are returned to the state of origin for its use. The BRFSS unit provides technical assistance to states on methodological issues such as sample selection, data quality, weighting, and the interpretation of findings. Weighted subsets of ACBS data, documentation, analysis guidance, and asthma prevalence tables are made broadly available through the BRFSS Web site at http://www.cdc.gov/brfss/acbs/index.htm. The ACBS methods are described in more detail in Part B.

Asthma data needs to be available at the state level to track the burden of the disease, monitor adherence to asthma guidelines, direct and evaluate interventions undertaken by asthma control programs located in state health departments. State health departments have the primary role of targeting resources to reduce

the burden of asthma. To make asthma data available to them, the CDC NACP saw the need to develop the ACBS at a state level to provide more detailed asthma data for disease tracking and interventions.

A.2 Purpose and Use of the Information Collection

CDC's NCCDPHP Division of Population Health administers the BRFSS parent survey, which provides the foundation for the ACBS administration and data collection (**Attachments 5a –5f**). The BRFSS questionnaire data (**Attachment 6**) and the ACBS questionnaire data (**Attachments 5e – 5f**) are combined for the final ACBS analysis file to link demographics, behavioral, and risk factor data with the asthma-specific data on the ACBS at the state level. Data linking is done by a sequence number (person ID) that is scrambled on the public file.

Data collection, based on state-level sampling, permits the analyses of data at the local level when sample sizes within county or Metropolitan Statistical Areas are large enough for statistical interpretation. The ability to identify state and sub-state differences optimizes program interventions designed by state health departments.

The ACBS will be used for a number of purposes by a diverse set of users. The primary uses of the data are listed below:

- States use the ACBS data to help them establish and track state and local health objectives, plan health programs, implement disease management strategies, and monitor trends.
- The ACBS data will be used to report asthma prevalence by state. See the 2013 prevalence tables for specific details (https://www.cdc.gov/brfss/acbs/2013_tables_LLCP.html). State health department websites as well as a CDC website will be used as platforms to report ACBS data.
- The ACBS data will inform a variety of data resources, programs and organizations which use the data for asthma surveillance. These include but are not limited to National Institute for Occupational Safety and Health analysis and reporting of work related asthma and states monitoring of Healthy People 2020 objectives.
- The ACBS data will be used to report asthma estimates from information reported by adult respondents residing in the participating U.S. states, D.C., and Puerto Rico.
- A publicly available annual ACBS dataset will be used by public health officials in government at the national, state, and local level as well as by researchers at university and non-profit organizations. Information will be used for program evaluation and reporting related to health status, risk factors, health care system use, medication use, and various indicators of asthma such as asthma attack prevention behaviors and asthma control levels. Data will be appropriate for trend analyses, tests of differences among (demographic) subpopulations, multivariate analyses of health outcomes and other statistical processes.
- The ACBS data may be used to draw comparisons from data taken from identical and/or similar questions on other surveys using other modes thereby creating a means for validation and comparisons across population samples.

Additionally, the ACBS questionnaires (**Attachments 5e–5f**) include information about the health and experiences of people with asthma on their age at first diagnosis (incidence), asthma attack prevention measures, medication use, treatment modalities, severity level, and demographic information. Key

questionnaire features of the information collection help to address critical questions surrounding the health and experiences of persons with asthma, such as:

- What health, socioeconomic, and environmental risk factors exist for asthma?
- How well are asthma attacks and episodes, as well as symptoms, controlled through medications and preventive measures?
- What is the range of ages at first diagnosis with asthma?
- Are asthma medications taken on a regular basis to prevent asthma symptoms or used more often as a bronchial dilator during attacks?
- What impact does asthma have on physical activities?
- What modes of care are most often utilized by persons with asthma– urgent or emergent care, hospital care, or primary care?
- Are persons with asthma educated regarding signs and symptoms of asthma and do they understand what to do when having an asthma attack?
- Have persons with asthma received a written asthma management plan from their health care provider?
- What modifications have been made to the home, school or work environments of persons with asthma?
- What treatment modalities are most often used by persons with asthma?
- Is use of asthma medication consistent with prescription guidelines?

Consequences of not collecting the ACBS data are below:

- ACBS data is used to calculate and derive the NACP Congressional Justification Performance Measure which cannot be produced if ACBS information collection is not done.
- State level adult and child asthma prevalence data will not exist.
- Data for the proposed Federal Action Plan to Reduce Racial and Ethnic Asthma Disparities indicators will not be produced.
- Several state level Healthy People 2020 objectives cannot be monitored.
- State level incidence rates cannot be produced.
- State level intervention planning and monitoring of asthma severity, control, and management and education as indicated in the expert panel three report will not be conducted.

A.3 Use of Improved Information Technology and Burden Reduction

The ACBS data will be collected using list-assisted random digit dialing (RDD) landline and cell phone telephone samples. Given the need for state-level samples that are large enough for statistical analyses, telephone surveys offer a cost effective method of data collection. Interviewers will use Computer Assisted Telephone Interview (CATI) software to enter data directly into a database. Use of CATI software promotes efficiency in two ways: skip patterns can be programmed to route respondents only to questions that they are eligible to answer, and real-time quality control checks can be used to eliminate some errors which may have been caused by manual data entry procedures.

A.4 Efforts to Identify Duplication and Use of Similar Information

Beyond asthma prevalence estimates, for most states, the ACBS provides the only sources of adult and child asthma program and case management data at the state level. Data on these topics are available at the national level through other CDC surveys (see below), but do not include sufficient sample size to determine whether there are measureable changes/trends in health risk behaviors at lower geographic levels.

The National Center for Health Statistics surveys collect data on asthma prevalence, asthma-related deaths (mortality), and several indicators of asthma-related illness (morbidity), such as hospitalizations and emergency department visits (The National Hospital Discharge Survey and the National Ambulatory Medical Care Survey). National surveys such as the National Health Interview Survey (NHIS, OMB Control No. 0920-0214, expiration date 1/31/2019), the National Health and Nutrition Examination Survey (NHANES; OMB Control No 0920-0950, expiration date 12/31/2017), among others offer data for prevalence estimates at the national level. These data provide a good basis for analyzing national trends, establishing national goals, and assessing progress toward those goals, but not all can be analyzed by states and they don't have detailed data needed at the state level. The ACBS differs in that it samples at state levels, and produces direct, not modeled, estimates for state and local geographic jurisdictions.

In some cases, state prevalence may be modeled by other data collection. The NHIS has been used to model prevalence estimates at the state level. However they do not provide sufficient data from which direct state estimates can be derived. Moreover, in most instances state level data modeled from national surveys use national level control totals for weighting, while the ACBS uses (sub) state control totals for all post-data collection raking weights. National surveys use modeled estimates to obtain state and local prevalence estimates, however, these modeled estimates can't be used to evaluate interventions that public health programs at the state and local level may have implemented.

A.5 Impact on Small Businesses or Other Small Entities

There will be no impact on small business.

A.6 Consequences of Collecting the Information Less Frequently

Trend analyses created from annual data would be interrupted by less frequent data collection. Annual Healthy People 2020 objectives and the annual NACP Congressional Justification Performance Measures (derived from analyzing the ACBS data) could not be produced without this information collection. Interruption in telephone data collection can be costly due to the loss of continuity from year-to-year.

A.7 Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

There are no special circumstances with this information collection package. This request fully complies with 5 CFR 1320.5.

A.8 Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A. 60-day Federal Register Notice was published in the Federal Register on August 10, 2016, vol. 81, No.54, pp. 52874 (see **Attachment 2**). No public comments were received for this request.

B. Table A.8.1 lists individuals involved in the data collection partnership with the CDC NCCDPHP Division of Population Health, which is the program responsible for implementing the BRFSS and ACBS survey. Monthly calls are conducted to discuss the availability of existing data, the clarity of instructions, recordkeeping, disclosure, reporting format, and on the data elements to be recorded and reported for each data collection year.

Table A.8.1 CDC Consultants

CDC	CDC
Wilmon Murphy Programmer and Project Manager Northrop Grumman Contractor Centers for Disease Control and Prevention National Center for Chronic Disease Prevention Division of Population Health Population Health Surveillance Branch 4770 Buford Hwy MS F-78 Atlanta, GA 30341 wcm5@cdc.gov	**Ernest Kelly** Software Development Analyst Northrop Grumman Contractor Centers for Disease Control and Prevention National Center for Chronic Disease Prevention Division of Population Health Population Health Surveillance Branch 4770 Buford Hwy MS F-78 Atlanta, GA 30341 ynb2@cdc.gov
Ajay Sharma Software Development Analyst Northrop Grumman Contractor Centers for Disease Control and Prevention National Center for Chronic Disease Prevention Division of Population Health Population Health Surveillance Branch 4770 Buford Hwy MS F-78 Atlanta, GA 30341 aus6@cdc.gov	

Table A.8.2 lists state BRFSS coordinators currently participating on monthly ACBS data collection conference calls. These coordinators represent state health department staff responsible for the oversight of the ACBS in their respective state. They have been actively involved in decisions about the questionnaire, availability of data, record keeping, reporting format, and data elements to be recorded, disclosed, and reported. Some of these coordinators have been involved in the ACBS project since the first data collection year in 2006.

Table A.8.2 State Consultants

2015 BRFSS Coordinators	2015 BRFSS Coordinators
Coordinator: Sandy Kwong, M.P.H. Research Scientist Supervisor	**Coordinator: Diane Aye, MPH, PhD** Connecticut Department of Public Health

Survey Research Group California Cancer Registry Chronic Disease Surveillance and Research Branch Phone: 916-731-2532 Email: sandy.kwong@cdph.ca.gov	P.O. Box 340308, MS#11PSI Hartford, Connecticut 06134-0308 Phone: 860-509-7756
Coordinator: Junwei, Jiang, MPH Florida Department of Health Bureau of Epidemiology, Chronic Disease Epidemiology and Surveillance Section 4052 Bald Cypress Way, #A-12 Tallahassee, Florida 32399-1720 Phone: 850-245-4444 ext 244	**Coordinator: Madhavi Vajani, MPH** Georgia Department of Human Resources Division of Public Health 2 Peachtree St., NW 14.493 Atlanta, Georgia 30303 Phone: 404-657-2628
Coordinator: Florentina Reyes-Salvail, MSc. State Department of Health Office of Planning, Policy and Program Development P.O. Box 3378 Honolulu, Hawaii 96801-3378 Phone: 808-586-4509 Email: florentina.salvail@doh.hawaii.gov	**Coordinator: Donald H. Shepherd, PhD** Iowa Department Public Health Center for Health Statistics 321 East 12th Street, Lucas SOB Des Moines, Iowa 50319-0075 Phone: 515-281-7132
Coordinator: Bruce Steiner, MS Illinois Department of Public Health Center for Health Statistics 525 West Jefferson Springfield, Illinois 62761 Phone: 217-785-1064	**Coordinator: Linda Stemnock** Indiana State Department of Health Behavioral Risk Factor Surveillance System Two North Meridian St- 6E Indianapolis, Indiana 46204 Phone: 317-233-7536
Coordinator: Natalie Jeanie Santaularia, MPH Kansas Dept of Health and Environment Bureau of Health Promotion 1000 SW Jackson, Suite 230 Topeka, Kansas 66612-1274 Phone: 785-368-7355	**Coordinator: Laurie M. Freyder, MPH** Louisiana DHH/Office of Public Health Health Improvement Support Unit 1450 Poydras Street, Suite 1936 New Orleans, Louisiana 70112 Phone: 504-568-8191 Email: Laurie.FreyderAla.gov
Coordinator: Maria McKenna Massachusetts Department of Public Health Health Survey Program 250 Washington Street, 6th Floor Boston, Massachusetts 02108-4619 Phone: 617-624-5643 Email: maria.mckenna@state.ma.us	**Coordinator: Melissa Damren** Maine Centers for Disease Control and Prevention Department of Health and Human Services 244 Water Street, 2nd Floor Augusta, Maine 04333-0011 Phone: 207-287-1420 Email: melissa.damren@maine.gov
Coordinator: Chris Fussman, MPH Michigan Department of Community Health Community Public Health Agency 201 Townsend Street, P.O. Box 30195 Lansing, Michigan 48909 Phone: 517-335-8144	**Coordinator: Nagi Salem, PhD** Minnesota Department of Health Center for Health Statistics 85 East 7th Place St. Paul, Minnesota 55164-0882 Phone: 651-201-5996
Coordinator: Janet S. Wilson, M.Ed, MPA Missouri Department of Health and Senior Services	**Coordinator: Ron McAnally** Mississippi State Health Department Public Health Statistics

Office of Epidemiology 920 Wildwood Drive Jefferson City, MO, Missouri 65102-0570 Phone: 573-526-6660	222 Market Ridge Dr. Ridgeland, MS 39157 Phone: 601-206-8253 Email: Ron.McAnally@msdh.ms.gov
Coordinator: Emily Ehrlich Montana Dept. of Public Health and Human Services Public Health and Safety Division 1400 Broadway, Room A113 Helena, Montana 59620 Phone: 406-444-2973	**Coordinator: Mihaela Johnson, PhD** Department of Regulation and Licensure Office of Health Statistics P.O. Box 95026/301 Centennial Mall South Lincoln, Nebraska 68509 Phone: 402-471-1063
Coordinator: Kim Lim, Ph.D. MPH Division of Public Health Services Health Statistics and Data Management 29 Hazen Drive Concord, New Hampshire 03301-6527 Phone: 603-271-4671	**Coordinator: Marie-Carme Franklin, MPH** Center for Health Statistics NJ Dept. of Health and Senior Services 225 East State Street, 2nd Floor PO Box 360 Trenton, NJ 08625 Phone: 609-984-6178
Coordinator: Lori Zigich New Mexico Department of Health Epidemiology & Response Division P.O. Box 26110, 1190 St. Francis Dr., Suite N-1350 Santa Fe, New Mexico 87505 Phone: 505-476-3569	**Coordinator: Brad Towle, MA, MPA** Department of Human Resources Nevada State Health Division 4150 Technology Way, Suite 104 Carson City, Nevada 89706 Phone: 775-684-4243
Coordinator: **Mycroft Sowizral, Ph.D** Bureau of Chronic Disease Evaluation and Research New York State Department of Health Corning Tower, Empire State Plaza Albany, New York 12237-0679 Phone: 518-473-0673	**Coordinator: Jill Garratt** Ohio Behavioral Risk Factor Surveillance System Bureau of Healthy Ohio Division of Prevention and Health Promotion Ohio Department of Health 246 North High St. Columbus, OH 43215
Coordinator: Rebecca Falkenstern Oklahoma State Department of Health Health Care Information 1000 NE 10th Oklahoma City, Oklahoma 73117-1299	**Coordinator: Renee K. Boyd** Oregon Health Division Center for Health Statistics PO Box 14050 Portland, Oregon 97323-0050 Phone: 971-673-1145
Coordinator: Alden Small, Ph.D. Pennsylvania Department of Health Division of Statistical Support 555 Walnut Street - 6th Floor Harrisburg, Pennsylvania 17101-1900 Phone: 717-265-2548	**Coordinator: Ruby A. Serrano-Rodriguez, MS, DrPH(c)** Puerto Rico Department of Health Puerto Rico-BRFSS PO Box 70184 San Juan, Puerto Rico 00936-8184 Phone: 787-274-7828
Coordinator: Tara Cooper, MPH Rhode Island Department of Health	**Coordinator: Rebecca Wood, MSHP** Texas Department of State Health Services

Center for Health Data and Analysis 3 Capitol Hill, Room 407 Providence, Rhode Island 02908 Phone: 401-222-7628	Center for Health Statistics, MC 1898 PO Box 149347 Austin, Texas 78714-9347 Phone: 512-776-6579
Coordinator: Rachel Eddington, MS Utah Department of Health Office of Public Health Assessment P.O. Box 142101 Salt Lake City, Utah 84112 Phone: 801-538-9466 Email: reddington@utah.gov	**Coordinator: Jessie Hammond** Vermont Department of Health Division of Health Surveillance 108 Cherry Street, Room 304 Burlington, Vermont 05402 Phone: 802-863-7663
Coordinator: Anne Ziege, Ph.D. Wisconsin Department of Health and Family Services Center for Health Statistics P.O. Box 309 Madison, Wisconsin 53701-0309 Phone: 608-267-9821	

A.9 Explanation of Any Payment or Gift to Respondents

CDC will not provide payments or gifts to respondents.

A.10 Protection of the Privacy and Confidentiality of Information Provided by Respondents

ACBS is implemented through BRFSS. For the prior approved BRFSS information collection (OMB Control No. 0920-1061, expiration date 3/31/2018) it has been determined that the Privacy Act does not apply. The BRFSS data is collected from adults, aged 18 years of age and older, and parents or guardians of randomly selected children residing in the 50 states, District of Columbia, Puerto Rico, and Guam using list-assisted RDD. Additional details on the BRFSS processes are described in the BRFSS Data User Guide available at http://www.cdc.gov/brfss/data_documentation/pdf/userguidejune2013.pdf. Information in identifiable form (IIF) such as telephone number, zip code is collected for follow-up purposes but the final BRFSS datasets delivered to CDC do not retain the any identifying information. Only de-identified data is sent to CDC. Therefore Privacy Act does not apply.

Likewise for the subset of 40 participating ACBS states (**Attachment 3**), the NCEH Information Systems Security Officer has reviewed the package and also determined that Privacy Act does not apply to this collection. Therefore, a system of records notice (SORN) will not be created for the ACBS.

IIF (e.g., name, initials) is collected **(Attachments 5a–5d)** by the states during field operations as part of routine collection for the purposes of follow up and to ensure that the completion of the interview with the respondents. The final ACBS datasets delivered to CDC will not contain the participant's initials or name.

Since the ACBS sample is a subset of BRFSS, respondents for ACBS are BRFSS adults, 18 years and older, in participating states who report ever being diagnosed with asthma. Some states include children,

below 18 years of age, who are randomly selected subjects in the BRFSS household. In participating states, parents or guardians serve as ACBS proxy respondents for their children ever diagnosed with asthma. Children do not respond directly to the ACBS questionnaire. If both the BRFSS adult respondent and the selected child in the household have asthma, then only one or the other is eligible for the ACBS. The ACBS enrollment process is presented in a flowchart (**Attachment 7)**.

Field operations are managed by state health departments and/or their contractors following ACBS guidelines. ACBS follow-up is conducted within two weeks after the BRFSS interview. Information collection is implemented by state health departments or their designees, including screening **(Attachments 5a–5d)**, informing them of the voluntary nature of the collection, obtaining verbal consent, and administering the telephone interview **(Attachments 5e or 5f).** States administer the ACBS questionnaire without change. States submit data to CDC as text files for final cleaning, weighting, the production of analysis datasets, and other technical assistance as needed.

Datasets provided to the states at the end of the data collection year include a large number of variables on calling attempts, final calling outcomes, BRFSS questionnaire item responses, ACBS questionnaire responses, and calculated variables. A subset of the de-identified data set from BRFSS and ACBS questionnaire responses is available to the public on the BRFSS website (http://www.cdc.gov/brfss/acbs/index.htm).

The CDC maintains a non-public upload website by which data are submitted monthly or quarterly in a text file format. CDC does not transmit data from one state to any other, with the exception of cell phone interviews of persons who have an area code from one state, but who actually live in another state. Telephone numbers are not linked to respondents. The states **(Attachment 3)** keep files on their own record systems which contain their own RDD telephone samples separately from files which include responses to questionnaire items. CDC receives only de-identified records. States keep responses to the ACBS questionnaire separately from sample files. State level data sets are owned by individual states. A subset of state datasets with combined BRFSS and ACBS data in SAS format are provided for public use. Public use datasets are stripped of a number of variables which provide locational information on the respondents (including zip codes, county identifiers for counties with adult populations of less than 10,000).

Access to state datasets will be limited to the states themselves and CDC contractors and staff who conduct weighting and data cleaning procedures. CDC security measures include: 1) Physical controls: CDC facilities are secure, ID accessed buildings. Data will not be stored in hard copy formats; and 2) Technical controls: All electronic data are stored on secured servers protected with firewalls and passwords. All employees are trained on data security measures by taking appropriate Health and Human Health Services (HHS) courses online. All data collection and records management practices and systems adhere to HHS and CDC IT policies and procedures.

States are responsible for developing and maintaining procedures to ensure respondents' privacy, assure and document the quality of the interviewing process, and supervise and monitor trained interviewers.

A.11 Institutional Review Board (IRB) and Justification for Sensitive Questions

The ACBS information collection has been reviewed by the NCEH/ATSDR Human Subjects Contact, and this CDC collection has been classified non-research as data collected by the states is not generalizable beyond the state population. A copy of the NCEH-ATSDR research determination can be found in **Attachment 8a**.

BRFSS exempt approval memo from CDC Human Research Protection Office is provided in **Attachment 8b**. Some state IRBs require that BRFSS respondents be specifically asked if their BRFSS responses could be linked to their ACBS responses. Other state IRBs do not. If consent is denied, the ACBS is not conducted and there will be no record in the file. The state-specific consent scripts are maintained by each participating state. Individuals participating in the ACBS are informed that they do not have to participate and that they may refuse to answer any question during the consent/permission process and before survey administration. See **Attachments 5e-5f** for CDC suggested consent templates.

The BRFSS includes standard demographic questions (such as race and income category) which may be considered sensitive. This information is included on the ACBS final dataset. There are no questions of sensitive nature on the ACBS.

A.12 Estimates of Annualized Burden Hours and Costs

The estimated burden to respondents is summarized in Table A12.1. below. Within the selected BRFSS household, ACBS respondents are adults 18 years or older with an asthma diagnosis or parents or guardians of a randomly selected child, below 18 years, with an asthma diagnosis. Children do not respond directly to the ACBS; parents or guardians provide proxy responses for children. Respondent burden is estimated separately for each step. The number of interviews varies from state to state - based on the population size, lifetime asthma prevalence, and response rate of each state. For states conducting both landline and cellphone samples, approximately 70 percent of interviews are currently conducted on landlines and 30 percent on cell phones. The burden calculation was computed based on the states that implemented both landline and cellphone samples in 2013 (29 states for adult and 24 states for child) because this will be the data collection mode for all participating states starting in 2015. Since the cooperation rate (based on AAPOR cooperation rate #2 – **Attachment 12**) in 2013 was 56.8 percent for landline respondents and 53.9 percent for cellphone respondents, it is estimated that 25,669 landline respondents and 11,214 cell phone respondents will complete the consent screening questions. The estimated burden per screening response is one minute. The ACBS screener documents are provided in (**Attachments 5a–5d)**.

Respondents who are eligible for ACBS and agree to participate will be contacted again within two weeks to complete the ACBS questionnaire (**Attachments 5e–5f)**. We estimate that 16,555 respondents screened on landline phones and 7,286 respondents screened on cell phones will participate in the ACBS data collection (total of 23,841respondents).

ACBS questionnaires are provided in **Attachments 5e–5f**. For ACBS, states administer one questionnaire for adult respondents and a similar questionnaire for the randomly selected child in the household. Again,

if both the BRFSS adult respondent and the selected child in the household have asthma, then only one or the other is eligible for the ACBS. The ACBS enrollment process is presented in **Attachment 7**.

We estimate the average burden for the ACBS survey at 10 minutes per response. The burden hour estimates reflect the landline and cell phone data collection method that will be used starting 2013. Additionally, the burden table accounts for reporting burden incurred by the states for the monthly or the quarterly data submission to CDC. For the purpose of this information collection, monthly data submission is assumed for the time burden and the average burden for the ACBS data reporting is estimated at three hours per response.

The total burden hours requested is **6,029**.

Table A.12-1. Estimated Annualized Burden to Respondents

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hrs.)	Total Burden Hours
BRFSS Adults	ACBS Landline Screener – Adult	21,424	1	1/60	357
	ACBS Cell Phone Screener – Adult	8,976	1	1/60	150
BRFSS Parents or Guardians of Children	ACBS Landline Screener – Child	4,245	1	1/60	71
	ACBS Cell Phone Screener – Child	2,238	1	1/60	37
ACBS Adults	ACBS Adult Consent and Survey – 2013	19,954	1	10/60	3326
ACBS Parents or Guardians of Children	ACBS Child Consent and Survey – 2013	3,887	1	10/60	648
State BRFSS Coordinators	ACBS Data Submission Layout	40	12	3	1440
Total					6,029

Annualized burden costs are summarized in the table below. These calculations assume the average hourly wage of $23.23 for all jurisdictions included in the ACBS. Hourly rates were taken from the most recent publically available Current Employment Statistics of the Bureau of Labor Statistics and are based upon May 2015 the average hourly earnings for from the Current Employment Statistics Survey conducted by the Bureau of Labor Statistics (available at http://www.bls.gov/oes/current/oes_nat.htm)

Table A.12-2. Estimated Annualized Cost to Respondents

Type of Information Collection	Form Name	Number of Respondents	Total Burden Hours	Average Hourly Wage Rate	Total Respondent Costs
BRFSS Adults	ACBS Landline Screener – Adult	21,424	357	$23.23	$ 8,293.11
	ACBS Cell Phone Screener – Adult	8,976	150	$23.23	$ 3,484.5
BRFSS Parents or Guardians of Children	ACBS Landline Screener – Child	4,245	71	$23.23	$ 1,649.33
	ACBS Cell Phone Screener – Child	2,238	37	$23.23	$ 859.51
ACBS Adults	ACBS Adult Consent and Survey – 2013	19,954	3326	$23.23	$ 77,262.98
ACBS Parents or Guardians of Children	ACBS Child Consent and Survey – 2013	3,887	648	$23.23	$ 15,053.04
State BRFSS Coordinators	ACBS Data Submission Layout	40	1440	$23.23	$ 33,451.2
Total					$ 14,0053.67

A.13 Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

There are no maintenance or capital costs to respondents.

A.14 Annualized Cost to Federal Government

Costs that are presented below include data collection, weighting and sampling as well as data distribution (i.e., websites and production of data sets). These are based on the 2013 funds provided to states for data collection as well as internal BRFSS costs.

Annualized Cost to the Federal Government

Funds provided to 39 ACBS awardee states and Puerto Rico	$1,152,413
Funds provided to BRFSS (administration and data processing)	$550,000
Total	$1,702,413

A.15 Explanation for Program Changes or Adjustments

There are no anticipated major program changes or adjustments to report at this time. We do anticipate updating the questionnaire periodically to include new medications. Future substantive revisions to OMB approved forms or methods will be submitted as new ICRs. Future non-substantive modifications to OMB approved forms or methods will be submitted as change requests.

A.16 Plans for Tabulation and Publication and Project Time Schedule

As funding allows, each annual ACBS data collection will be repeated on a rolling basis. Timing from collection initiation to public data release is typically a three-year process.

For each annual collection, data collection for the ACBS questionnaire typically begins no later than February. BRFSS Coordinators submit data quarterly to CDC for editing and cleaning. CDC edits, cleans, and weights the ACBS data. CDC returns the final weighted data to the BRFSS coordinators. Datasets and supporting technical documentation are then made available for public use.

Table A.16.1. Typical Project Time Schedule

Activity	Approximate Time Schedule
Data collection	February (Year 1) – March (Year 2)
Monthly or quarterly data submission by BRFSS Coordinators	March (Year 1) – April (Year 2)
Data cleaning and editing by CDC	May (Year 1) - December (Year 2)
Weighting by CDC	December (Year 2) – April (Year 3)
Final datasets to states from CDC	May (Year 3) – June (Year 3)
Final public use datasets with supporting documentation by CDC	July (Year 3)

The CDC assists the states by weighting each states' dataset annually. Once all data are received from the states, CDC staff members apply individual respondent weights to ensure that the persons interviewed most accurately reflect the population of each state who report ever being diagnosed with asthma (lifetime prevalence). To produce the ACBS final weight, the BRFSS final weight is adjusted for loss of sample between the BRFSS interview and the ACBS interview. Post-stratification weighting methods match the demographic characteristics of the respondent to those of the population who report ever being diagnosed with asthma (lifetime prevalence) for each state. Weighted ACBS data represent results that have been adjusted to compensate for nonresponse at the BRFSS interview and at the ACBS interview.

A.17 Reason(s) Display of OMB Expiration Date is Inappropriate

Not applicable. The expiration date of OMB approval will be displayed.

A.18 Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.